Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

OKLAHOMA SPINE HOSPITAL
236 NW 62ND ST
OKLAHOMA CITY OK 73118-7422

Respondent Name

CONTINENTAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-04-4236-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Work Comp claims are paid according to the DRG rate, number of days stayed and cost of implants if implants are used."

Amount in Dispute: $1,632.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Table of Disputed Services: "Texas Fee Guides applicable to this injury. Clm properly paid. See proper EOB's & Okla Guidelines."

Response Submitted by: Gallagher Bassett Services, 2644 San Pedro #400, San Antonio, TX 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2003	Inpatient Hospital Service	$1,632.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.401(b)(1), (c)(1) and (c)(3) sets out the payment policies and procedures for the Division of Workers' Compensation and it's system participants to calculate the MAR for inpatient surgical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 25, 2003 and April 28, 2003
   - 111-002 – FHN contract status indicator 02 – non-contracted provider.
   - F – Fee Guideline MAR reduction.
   - 00097 – Use once per bill.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Is this request for medical fee dispute resolution an inpatient hospital dispute?
4. Was the requestor reimbursed in accordance with 28 Texas Administrative Code §134.401 and is the requestor entitled to reimbursement?

Findings

1. The requestor provided surgical services in the state of Oklahoma on March 26, 2003 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code 133.307.
3. According to 28 Texas Administrative Code §134.401(b)(1)(B) Inpatient Services—Health care, effective August 1, 1997, 22 TexReg 6264, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital. Review of the submitted UB-04 finds that the admission time, in box 18, to be 12 p.m. and discharge time, in box 21, to be 10 a.m.; no other documentation was submitted to support whether this is an inpatient or outpatient admission.
4. Review of the submitted documentation finds that the respondent paid the requestor $1,118.00 for a one-day hospital stay. According to 28 Texas Administrative Code §134.401(c)(1) the standard per diem amount to be used in calculating the reimbursement for acute care inpatient services for a surgical intervention is $1,118 per day. The reimbursement formula defined in (c)(3)(B) is the length of stay multiplied by the standard per diem amount equals the workers' compensation reimbursement amount; therefore, the respondent has paid correctly and additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 9, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.